DIVISION OF CLINICAL AND ABNORMAL PSYCHOLOGY. NEWSLETTER, Vol. 4, No. 2, Supplement

Report of the Committee on Psychotherapy of the Division of Clinical and Abnormal Psychology

This report has been condensed for publication in the Division Newsletter. A considerable amount of space is given to a critical discussion of how the data were collected, how they were systematized, and how much validity can be claimed for any conclusions which are based upon the questionnaire returns. It seemed wise to give this kind of information preference. Consequently, it was not feasible to reprint the complete questionnaire questions, nor to point up possible ambiguity, overlapping, misleading terminology, etc. These potential scurces of error have been carefully scrutinized in the systematizing process and are referred to in specimen illustrations in the discussion.

Any Division member who is interested in seeing the unabridged report can borrow it from the Committee. This applies also to the preliminary report which the Committee prepared and which was read at the 1949 Denver meeting of the APA, "The Role of the Clinical Psychologist in the Teaching and Practice of Psychotherapy". Forward your request to the Chairman of the Psychotherapy Committee, Dr. Max Hutt.

I. Introduction

The Committee on Psychotherapy was given the assignment of systematizing the replies to the Questionnaire on the Practice of Psychotherapy and Counseling. Its second assignment was to make recommendations for training and practice on the basis of the systematization. First, we say a few words about the background and the goal of the work of the Committee.

Members of the Division, especially officers and committee members, have found themselves handicapped by the non-existence of any over-all information about the nature and extent of counseling and psychotherapeutic activities by members of the APA. The question for which an answer was lacking was: Who (age, training, and experience) was doing what (vocational guidance, group therapy, psychoanalysis, non-directive counseling, etc.) where (school, VA hospital, private practice, etc.) in what role-relationship to members of related professions (especially medical) to whom (age, problem, diagnostic category). The Division was also interested in getting an answer to the related question: How many members of the Association have felt needs, deficiencies, and difficulties in consequence of engaging in counseling and psychotherapeutic practice? Representative, quantitative answers to these questions, it was felt, would provide the Division, and possibly the Association, with a better factual basis than was presently available for formulating policies, making plans, and taking action on numerous issues of importance for large segments of the Association membership.

Accordingly in 1948 a committee of the Division, the immediate predecessor of the present committee, took steps designed to remedy this informational deficiency. Dr. Margaret Brenman was the chairman of this committee. Her committee circulated two questionnaires. The first, a preliminary postcard inquiry, was sent to the entire membership of the Association (5754). Respondents were asked to indicate whether they engaged in (1) psychotherapy only, (2) counseling only, (3) both, and whether they taught psychotherapy and/or counseling. 3727 (64%) of the membership replied to the first inquiry. 2578 (45% of the total membership and 69% of those replying) gave one or more affirmative answers. To these respondents a more extensive questionnaire was sent. 1333 members returned the second questionnaire. 31 of these were not filled out. About 50%, then, of those replying affirmatively to the first inquiry also replied to the second one.

The present Committee was appointed at the end of 1948. It was presented with the 1333 returns to the second inquiry, which consisted of 42 separate questions arranged in

eleven groups. The Committee was asked (1) to systematize the possible maximum of 55,000 answers and (2) to offer recommendations concerning training for and practice of psychotherapy and counseling.

The present and final report of the Committee gives (1) such information as we have about the sampling of population, the clarity of the questions asked, the accuracy and completeness of the answers given by the respondents, the rules and procedures used in coding and tabulating the responses. All these the reader needs as a critical framework for evaluating the representativeness and accuracy of the group picture of psychologists as counselors and psychotherapists presented in the tabulations of their replies to the 42 questions put to them. (2) The report presents the principal factual findings in 32 tables. Space does not allow presenting with each table the exact form of the question put to the respondents, the difficulties the respondents experienced in interpreting the question, the rules used in coding the responses, etc. (3) Tables 26 through 31 with the accompanying discussion constitute a special report on psychologists in the private practice of psychotherapy and counseling. (4) The recommendations presented relative to training and practice are offered with hesitation. There are several reasons for this. Few safe inferences can be drawn about the representativeness of the data. Unsuspected confusions on the part of the respondents about the intent of certain critical questions make the meaning of the responses to them ambiguous. Omission of answers to certain questions was very extensive. Another reason for hesitation is that recommendations involve interaction of facts with values and goals; and we are far from clear or certain about our goals and values. Finally the Committee has not discussed the recommendations at all thoroughly. We have had only one physical meeting, and that was not fully attended.

II. Evaluation of the Data

Confusions, omissions, and plain carelessness on the part of the respondents, as well as sampling errors which are impossible to estimate accurately, all combine to make the usefulness of the information from the two inquiries less than anticipated. Confusions of two kinds need to be noted. The first reflects a general confusion in the field concerning identities, similarities, and differences in the referents of terms designating methods and approaches used by psychologists in their work with individuals on problems of psycho-social adjustment. The most troublesome instance is found in the terms "counseling" and "psychotherapy". (Others will be noted in connection with the discussion of Table 18, Therapeutic Approach Used.) The Committee of the Division which composed the questionnaire apparently did not free itself from this confusion concerning counseling and psychotherapy. The first inquiry, for example, asks respondents to indicate whether they are doing "psychotherapy only" or "counseling only"; while the second inquiry lumps the two together, e.g., in question 6 on percentage distribution of time, respondents are asked to indicate what per cent of their time is given to "therapy (or counseling)".

A second source of confusion lay in the lack of clarity of some of the instructions in the second inquiry. These are noted beside the tables, the content of which is effected by the confusion.

In the second inquiry, omission of answers to certain questions by large percentages of the respondents reduces the value of the data. The chief ones may be noted here. 49% did not indicate their present principal employment. 35% failed to record their division memberships. 22% omitted a statement of the preferred distribution of their time. 36% did not report the types of adjustment problems which they work with most frequently.

Plain carelessness in replying also reduces the dependence we can place on the tabulated data. Indeed, if the two instances which we have identified are at all representative, the accuracy of the responses is extremely low. In question 1 on present employment,

346 respondents reply that they engage in some private practice, while in question 10 on private practice 597 state they engage in private practice, a difference of 11%. The second instance is even more striking. Several members of the Division questioned the accuracy of a percentage we reported at the Denver meeting, namely, that 52% of the respondents engage in "interpretive group therapy". Even though we had determined for the original coding and the transfer of the coded replies to Hollerith cards that the coding and transfer errors were less than 1%, we again checked this particular item for accuracy of coding and transfer on a random sample of 100 returns. The error was 1%. We then communicated with a random sample of 120 of the respondents, sending them copies of their answers to the item in question and asking them to indicate (as of the time when they originally replied) whether they had correctly checked this item. 90% of those who received the communication replied to it. 23% stated that they had checked the item erroneously. We know of no reason why this item should have been checked more inaccurately than most others.

A word should be said about possible inaccuracies in the tabulated data arising from processing the second questionnaire. These could occur in several ways. In coding free-answer and qualitative statements, distortions may occur as a function of forcing qualitative material into a quantitative mold or as a function of a code built on an inadequate sampling of the material to be coded. In the present instance a provisional code was tried against a sample of 200 returns, revised, and then applied to a second sample of 200. Very few revisions had to be made to adapt the code to the second sample. Notes on the adequacies of the code preface some of the tabulations of the data. Where none occur the question of the adequacy of the code does not arise. Clerical errors are possible at all stages of processing. We indicated in the preceding paragraph that at each step taken in the process of transferring the raw data to Hollerith cards, the conventional steps for determination of accuracy were taken.

Finally, we have the question of the representativeness of our sample. Our parent population is the membership of the APA. In 1948, when the two inquiries were made, the Association had 5754 members. 65% of these replied to the first inquiry. 39% (1441) of those who responded to the first inquiry indicated that they were either practicing psychotherapy only (227) or practicing counseling only (606) or practicing both of these only (608). (The data from the first inquiry are presented in tables 1 through 5). If our respondents to the first inquiry were a representative sample of the total membership, we could say that about 39% of the members (2244) were chiefly engaged in the practice of therapy or counseling or both. But the fact is we do not know whether our sample is representative. It seems likely that our sample is biased by containing a disproportionate number of respondents who are giving some or all of their time to psychotherapy or counseling.

Uncertainties also exist as to the representativeness of the sampling in the second inquiry. Since this second sample is drawn from the first, the biases contained in the first may also be present in the second. The present Committee understands that the second questionnaire was sent to the 2578 respondents to the postcard inquiry whose returns contained any affirmative answers. About half (1333) returned the second questionnaire. One source of bias has already been suggested: those who regard counseling as a different activity from psychotherapy, and, in their sense of counseling, are engaging in counseling only, failed in large numbers to return the second questionnaire. Generalization, then, from the samples, especially the second, to the parent population are hazardous.

III. Tabular Presentation of the Data

Note: In most of the tables data are given not only for the total group of respondents but for a "Therapy Group" of 662 respondents. This group is composed of all those respondents who are devoting 20% of more of their time to psychotherapy or counseling.

The "Special Group" of 42, data for which are given in tables 26 through 31, are those who are giving 40% of more of their time to private practice. Further criteria used in the selecting of the group are given in the note preceding Table 26.

Postcard Survey: Tables 1 through 5

Table 1

	Yes	No
Teaching of Psychotherapy	658	3042
Practice of Psychotherapy	1520	2180
Teaching of Counseling	825	2875
Practice of Counseling	2068	1632

* * * * * *

(Total membership of APA, 1948: 5754)

Number of cards with any marked "Yes"	2578
Number of cards marked all "No"	1121
Number of cards not tabulated for various reasons	21
Number of cards with no answers	7
Total number of cards returned	3727

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Number of cards marked "Yes" for

Practice of Psychotherapy only	227
Practice of Counseling only	606
Both of these only	608

Table 2

Numbers reporting Teaching of Counseling by States

States reporting	N	
5 or less	21	Alabama, Arkansas, Delaware, Georgia, Idaho (0), Maine, Maryland, Mississippi, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Utah, Vermont, West Virginia (0), Wyoming.
6 - 10	8	Arizona, Florida, Kentucky, Louisiana, Missouri, North Carolina, Tennessee, Virginia.
11 - 20	9	Colorado, Connecticut, District of Columbia, Iowa, Kansas, Nebraska, Oregon, Washington, Wisconsin.
21 - 30	4	Indiana, Minnesota, Texas, New Jersey.
31 - 100	6	California (94), Illinois (65), Massachusetts (33), Michigan (39), Ohio (57), Pennsylvania (54).
over 100	1	New York (116).

Table 3

Numbers reporting Practice of Counseling by States

States reporting	N	
5 or less	10	Arkansas, Idaho, Montana, Nevada, New Mexico, North Dakota, Rhode Island, South Carolina, South Dakota, Vermont.
6 - 10	7	Arizona, Delaware, Maine, Mississippi, Utah, Wyoming, West Virginia.
11 - 20	11	Alabama, Florida, Georgia, Louisiana, Maryland, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Virginia.
21 - 30	7	Colorado, Iowa, Kansas, Kentucky, Missouri, Tennessee, Washington.
31 - 100	9	District of Columbia (34), Connecticut (47), Indiana (51), Massachusetts (72), Michigan (87), Minnesota (59), New Jersey (66), Texas (33), Wisconsin (40).
over 100	5	California (234), Illinois (177), New York (401), Ohio (144), Pennsylvania (151).

Table 4

Numbers reporting Teaching of Psychotherapy by States

States reporting	N	
5 or less	26	Alabama, Arizona, Arkansas, Delaware, Florida, Idaho, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, West Virginia, Wyoming.
6 - 10	8	Colorado, Connecticut, Georgia, Iowa, Kentucky, Oregon, Tennessee, Washington.
11 - 30	8	District of Columbia (16), Indiana (17), Kansas (13), Minnesota (18), New Jersey (18), North Carolina (11), Texas (17), Wisconsin(12)
31 - 100	7	California (88), Illinois (51), Massachusetts (35), Michigan (32), New York (89), Ohio (38), Pennsylvania (46).

Table 5

Numbers reporting Practice of Psychotherapy by States

States reporting	N	
5 or less	17	Arkansas, Delaware, Idaho, Maine, Mississippi, Montana, Nevada (0), New Mexico, North Dakota, Rhode Island, South Carolina, South Dakota (0), Utah, Vermont, West Virginia, Wyoming, New Hampshire.
6 - 10	5	Arizona, Louisiana, Nebraska, Oklahoma, Virginia.
11 - 20	11	Alabama, Colorado, Florida, Georgia, Iowa, Kentucky, Maryland, Missouri, North Carolina, Oregon, Tennessee.
21 - 30	6	Connecticut, Indiana, Kansas, Texas, Washington, Wisconsin.
31 - 100	6	District of Columbia (31), Massachusetts (55), Michigan (65), Minnesota (42), New Jersey (53), Ohio (87).
over 100	4	California (200), Illinois (137),New York (306), Pennsylvania (102).

Extensive Questionnaire: Table 6 through 31

Table 6

PRINCIPAL PLACE OF EMPLOYMENT

	Therapy Group N-662		Total Group N-1302	
	#	%	#	%
1. Private practice	44	7	73	6
2. University	164	25	478	36
3. Private hospital	36	5	36	3
4. Mental hygiene or child guidance clinic (non-VA)	65	10	94	7
5. School system	34	5	75	6
6. VA installation	112	17	169	13
7. Vocational guidance bureau	25	4	37	3
8. Not classified	192	29	347	26

Table 7

AGE OF RESPONDENTS

	Therapy Group N-662		Total Group N-1302	
	#	%	#	%
1. 20-29 years	68	10	121	9
2. 30-39 years	298	44	529	40
3. 40-49 years	194	29	397	30
4. 50-59 years	80	12	171	13
5. 60 and over	22	3	50	4
6. omitted	9	1	34	3
Median age	39		40	

Table 8

HIGHEST DEGREE HELD*

	Therapy Group		Total Group	
	#	%	#	%
1. A.B., B.S.	23	4	35	3
2. A.M., M.S.	276	42	459	35
3. Ph.D.	308	47	706	58
4. Ph.D. & M.D.	7	1	10	1
5. A.M. & M.D.	-	-	4	-
6. Other	44	7	73	6
7. No answer	10	2	26	2

* Overlapping is due to combinations of degrees not specifically listed as combinations (e.g., "other" and Ph.D., etc.) The degrees are not necessarily in psychology.

Table 9

YEAR WHEN HIGHEST DEGREE WAS GRANTED

	Total Group N-1302	
	#	%
1. 1900-1909	9	1
2. 1910-1919	35	3
3. 1920-1929	129	10
4. 1930-1939	434	33
5. 1940-1949	665	51
6. Omitted	32	2

Table 10

APA MEMBERSHIP

	Therapy Group N-662		Total Group N-1302	
	#	%	#	%
1. Fellow	180	27	405	31
2. Associate	477	72	889	68
3. Affiliate	3	-	4	-
4. Omitted	2	-	5	-

Table 11

APA DIVISION MEMBERSHIP

		Therapy Group N-662		Total Group N-1302	
		#	%	#	%
1.	Clinical and Abnormal	238	36	454	35
2.	Experimental and Theoretical	10	2	38	3
3.	Personality and Social	48	7	106	8
4.	Evaluation and Measurement	37	6	83	6
5.	General	42	6	95	7
6.	Childhood and Adolescence	34	5	76	6
7.	Educational	28	4	72	6
8.	SPSSI	34	5	77	6
9.	Counseling and Guidance	115	17	215	16
10.	Omitted	264	40	457	35
11.	Other	90	14	244	19

Table 12

PRESENT POSITION

		Therapy Group N-662		Total Group N-1302	
		#	%	#	%
1.	Chief psychologist, director, chief of psychological service	98	15	194	15
2.	Department chairman, professor, associate professor, assistant professor of psychology	103	15	339	36*
3.	Professor, associate professor, assistant professor of education	9	1	42	3
4.	Instructor or lecturer	24	4	60	5
5.	VA trainee	28	4	36	3
6.	Psychologist in Civil Service	11	2	15	1
7.	Therapist in private practice	21	3	22	2
8.	Consultant	27	4	31	2
9.	Clinical psychologist or psychologist	164	25*	209	16
10.	Senior Psychologist	10	2	31	2
11.	Vocational or educational advisor	9	1	9	1
12.	Counselor	48	7	57	4
13.	Remedial worker	1	-	1	-
14.	Psychological intern or extern (non-VA)	1	-	1	-
15.	Personnel psychologist, personnel consultant, director of personnel	11	2	21	2
16.	Industrial psychologist	-	-	6	-
17.	Dean, assistant dean	13	2	30	2
18.	Director of research, research psychologist, research fellow	11	2	34	3
19.	Instructional position other than psychology	10	2	20	2
20.	Other	53	8	107	8
21.	Omitted	21	3	39	3

* Modal occupation

Table 13

TIME DISTRIBUTION

Diagnosis	Therapy Group N-662 Present #	Present %	Preferred*	Total Group N-1302 Present #	Present %	Preferred #	Preferred %
1. 0%	187	27		466	36	395	30
2. 1-9%	55	8		160	12	79	6
3. 10-19%	113	17		204	16	196	15
4. 20-39%	177	27		221	17	247	19
5. 40-59%	78	12		103	8	76	6
6. 60-79%	45	7		85	6	20	2
7. 80% or over	4	1		26	2	3	-
8. Omitted	-	-		34	3	286	22
Therapy or counseling							
1. 0%				127	10	105	8
2. 1-9%				192	15	47	4
3. 10-19%				294	23	136	10
4. 20-39%				356	27	370	28
5. 40-59%				154	12	232	18
6. 60-79%				87	7	82	6
7. 80% or over				65	5	48	4
8. Omitted				27	2	282	22
Clinical supervision							
1. 0%	419	63		796	61	652	50
2. 1-9%	57	9		110	8	50	4
3. 10-19%	110	17		188	14	172	13
4. 20-39%	62	9		136	10	128	10
5. 40-59%	13	2		31	2	10	1
6. 60-79%	1	-		4	-	3	-
7. 80% or over	-	-		1	-	1	-
8. Omitted	-	-		36	3	286	22
Research							
1. 0%	311	47		526	40	289	22
2. 1-9%	101	15		189	14	48	4
3. 10-19%	149	23		273	21	190	15
4. 20-39%	72	11		182	14	347	27
5. 40-59%	23	4		56	4	105	8
6. 60-79%	5	1		22	2	23	2
7. 80% or over	1	-		18	1	16	1
8. Omitted	-	-		36	2	284	22

* Not run

TIME DISTRIBUTION
(Cont'd)

	Therapy Group N-662			Total Group N-1302			
	Present		Preferred*	Present		Preferred	
Teaching	#	%		#	%	#	%
1. 0%	323	49		472	36	344	26
2. 1-9%	64	10		114	9	53	4
3. 10-19%	91	14		158	12	162	12
4. 20-39%	90	14		180	14	248	19
5. 40-59%	56	8		140	11	149	11
6. 60-79%	35	5		134	10	47	4
7. 80% or over	2	-		74	6	18	1
8. Omitted	-	-		30	2	281	22
Administration							
1. 0%	357	54		599	46	610	47
2. 1-9%	78	12		144	11	98	8
3. 10-19%	95	14		195	15	128	10
4. 20-39%	87	13		172	13	119	9
5. 40-59%	34	5		89	7	44	3
6. 60-79%	9	1		35	3	15	1
7. 80% or over	1	-		34	3	4	-
8. Omitted	-	-		33	2	284	22
Other							
1. 0%		*		1038	80	886	68
2. 1-9%				62	5	33	2
3. 10-19%				54	4	36	3
4. 20-39%				59	4	34	3
5. 40-59%				23	2	14	1
6. 60-79%				18	1	9	1
7. 80% or over				10	1	6	-
8. Omitted				37	4	284	22

*Not run

Table 14

NATURE OF TRAINING IN PSYCHOTHERAPY OR COUNSELING

(This question is a crucial one in the questionnaire. Therefore, comments are added which most clearly summarize the problems of coding the returns, interpreting answers, etc.)

Question 7a: "Are you largely self-taught?"

	Therapy Group N-622		Total Group N-1302	
	#	%	#	%
1. "Yes"	238	36	547	42
2. "No"	333	50	563	43
3. Qualified	42	6	92	7
4. Omitted	50	8	100	7

Question 7b: "Have you had didactic courses in therapy? If yes, describe briefly, indicating profession of teacher and your evaluation of satisfactoriness of this aspect of your training."

	Therapy Group N-622		Total Group N-1302	
	#	%	#	%
1. "Yes"	463	70	791	61
2. "No"	134	20	352	27
3. Qualified	24	4	53	4
4. Omitted	42	6	103	8

Question 7b: The meaning of didactic seemed to cause some problem here. If academic courses, such as abnormal, dynamic, or child psychology were listed, they were not coded unless there was a specification that there was a section of the course on psychotherapy. If comments on supervised training were included, they were held over and coded in 7c, which specifically relates to supervised training. About two-fifths of the respondents omitted the teacher's profession. One other problem that came up with respect to this question was the older people who said their training was satisfactory for the time but falls far short of the standards that are held to be satisfactory at present. These, however, were coded as satisfactory and similarly for other specifications with reference to the time of training. About one-half of the respondents failed to evaluate their training.

Question 7b: Psychotherapeutic Didactic Training- Profession of Teacher

	Therapy Group N-622		Total Group N-1302	
	#	%	#	%
1. Psychiatrist	156	24	275	21
2. Psychoanalyst	82	12	132	10
3. Psychologist	269	41	489	38
4. Social Worker	16	2	30	2
5. Non-directive counselor	76	12	122	9
6. Lay analyst	4	1	7	1
7. Other	44	7	75	6
8. Omitted (or no training)	239	36	547	42

Table 14 (cont.)

Question 7b: Satisfactoriness of Didactic Training

	Therapy Group N-662		Total Group N-1302	
	#	%	#	%
1. Excellent	140	21	239	18
2. Good or satisfactory	102	15	193	15
3. Fair	17	3	32	2
4. Unsatisfactory	44	7	77	6
5. Degree of excellence specified but highly variable	20	3	39	3
6. Omitted (or no training)	341	52	719	55

Question 7c: "Have you had practice under supervision? If yes, indicate profession of supervisor and your evaluation of intensity and quality of supervision."

Psychotherapeutic Training (practice under supervision and profession of supervisor)	Total Group #	%
1. No	334	25.7
2. Yes, psychiatrist	230	17.7
3. Yes, psychoanalyst or lay analyst	116	8.9
4. Yes, psychologist	170	15.0
5. Yes, non-directive counselor	68	5.2
6. Yes, while in service	55	4.2
7. Yes, via staff conference	67	5.1
8. Yes, other	73	5.6
9. Yes, profession of supervisor omitted	270	20.7
10. Omitted	25	1.9
11. Yes, psychiatrist and social worker	27	2.0
12. Yes, psychiatrist and psychologist	95	7.3

Psychotherapeutic Training (intensity and quality of supervision)	Total Group #	%
1. Intensive	336	25.8
2. Moderate	143	11.0
3. Nominal	104	7.9
4. Intensity specified, highly variable	41	3.1
5. No evaluation of intensity	689	52.9
6. Excellent	165	12.7
7. Good or satisfactory	66	5.1
8. Fair	4	.3
9. Unsatisfactory	32	2.5
10. No evaluation of quality	988	75.9
11. Degree of excellence specified, highly variable	17	1.3

Table 14 (cont.)

Question 7d, on personal therapy, was apparently too ambiguously phrased and the answers could not be tabulated.

Question 7e: "Do you ever feel any significant lacks in your training for psychotherapy or counseling?"

		Therapy Group N-662		Total Group N-1302	
		#	%	#	%
1.	No	150	23	254	20
2.	Yes, insufficient or inadequate supervision or consultation (including evaluation of own performance	151	23	340	26
3.	Yes, instruction in therapeutic techniques	71	11	139	11
4.	Yes, personal therapy and/or self insight	71	11	138	11
5.	Yes, insufficient training in projective or other diagnostic techniques	44	7	93	7
6.	Yes, insufficient knowledge of varied therapeutic viewpoints	35	5	64	5
7.	Yes, insufficient knowledge of theory of therapy	15	2	25	2
8.	Yes, insufficient variety of cases	21	3	39	3
9.	Yes, insufficient knowledge of abnormal psychology, dynamic or personality theory	30	5	43	3
10.	Yes, insufficient knowledge of other social sciences, e.g., anthropology, sociology	8	1	9	1
11.	Yes, insufficient experience with special groups, e.g., children, psychotics, etc.	35	5	65	5
12.	Yes, insufficient knowledge of non-directive techniques	30	5	66	5
13.	Yes, insufficient knowledge of group techniques	16	2	31	2
14.	Yes, insufficient knowledge of play techniques	11	2	15	1
15.	Yes, recording of interview	9	1	15	1
16.	Yes, criteria for evaluating progress or effectiveness of therapy	3	-	10	1
17.	Yes, depth therapy or analytic training	43	6	82	6
18.	Yes, insufficient knowledge of what approach to use with what patients	6	1	9	1
19.	Yes, other or no description	189	28	382	29
20.	Omitted	11	2	40	3

Question 7e: The following entries were not included in specific alternatives of the code: people who specified the lack of medical training or the lack of any other academic degree, e.g., a Ph.D. Such entries were coded as "Yes, other". There were a number of statements such as "Yes, any kind", or "Yes, all kinds of training; I had none". These were coded generally as "Yes, no description", since the statement was so broad that it was impossible to specify any particular lack. "Training for psychotherapy" was entered as training in technique. Of those who checked personal therapy as a lack in their own background, about 90% specified that they were referring to analysis. A few specified very definitely that it need not be analysis, and a few simply did not mention the type of therapy desired.

Table 14 (cont.)

Question 7f: "Would you be interested in receiving further training?"

		Therapy Group N-662		Total Group N-1302	
		#	%	#	%
1.	No	79	12	216	17
2.	Yes, work with experienced therapists or supervised work	138	21	273	21
3.	Yes, training in diagnostic or projective techniques	78	12	149	11
4.	Yes, brief advanced seminars, workshops or refresher courses	96	14	153	12
5.	Yes, training in interpretive or analytic approach	98	15	141	11
6.	Yes, training with particular group other than children or psychosomatic disorder	33	5	51	4
7.	Yes, training for work with children	20	3	37	3
8.	Yes, training for work with psychosomatic disorders	5	1	6	-
9.	Personal therapy	66	10	121	9
10.	Yes, familiarity with a variety of techniques	30	5	57	4
11.	Yes, training in play therapy	16	2	32	2
12.	Yes, training in group therapy, including psychodrama	22	3	52	4
13.	Yes, training in counseling or non-directive approach	68	10	133	10
14.	Yes, training in technique (not specified), practical training	77	12	152	12
15.	Yes, training in recent developments	24	4	43	3
16.	Yes, internship type of training	17	3	24	2
17.	Yes, instruction in theory of therapy	21	3	37	3
18.	Yes, recorded interviews to analyze	10	2	15	1
19.	Yes, training in dynamic or personality theory	29	4	50	4
20.	Yes, other or not description	193	29	354	27
21.	Omitted	7	1	32	2

Table 15

YEARS ENGAGED IN PSYCHOTHERAPY

		Therapy Group N-662		Total Group N-1302	
		#	%	#	%
1.	Up to and including 1 year	31	5	50	4
2.	2 years	75	11	120	9
3.	3 years	61	9	114	9
4.	4 years	58	9	100	8
5.	5 years	50	8	96	7
6.	6 to 8 years	103	16	180	14
7.	9 and 10 years	81	12	156	12
8.	11 and 15 years	97	15	207	15
9.	16 to 20 years	53	8	106	8
10.	21 years and over	34	5	99	8
11.	Omitted	19	3	72	6

Table 16

AGE OF PERSON TREATED

		Therapy Group N-662		Total Group N-1302	
		#	%	#	%
1.	Children	68	10	135	10
2.	Adolescents	70	10	158	12
3.	Adults	302	46	542	42
4.	Children and adolescents	35	5	79	6
5.	Children and adults	20	3	35	3
6.	Adolescents and adults	114	17	230	18
7.	Children, adolescents, and adults	38	6	72	6
8.	Omitted	11	2	43	3

Table 17

RANGE OF PROBLEMS WORKED WITH

		Total Group single checks		Total Group double checks	
		#	%	#	%
1.	Neurotic children	149	11	71	6
2.	Neurotic adolescents	284	22	58	5
3.	Neurotic adults	318	24	262	20
4.	Psychotic children and/or psychotic adolescents	62	5	5	-
5.	Psychotic adults	137	11	46	4
6.	Mental defectives	87	7	19	2
7.	Criminals	27	2	27	2
8.	Student adjustment problems	346	27	357	27
9.	Delinquents	82	6	30	2
10.	Minor maladjustments in family affairs	329	25	55	4
11.	Behavior problem children	204	16	167	13
12.	Other	130	10	107	8
13.	Five or more items checked	308	24	10	1
14.	Omitted	82	6	465	36

Table 18

THERAPEUTIC APPROACHES
(see discussion of Table 18 on page 21)

		Therapy Group N-662		Total Group N-1302	
		#	%	#	%
1.	Sex education	184	28	301	23
2.	Speech correction	78	12	135	10
3.	Vocational counseling	370	56	736	56
4.	Marital counseling	222	34	353	27
5.	Tutorial therapy (remedial teaching, etc.)	130	20	247	20
6.	Release therapy (therapist mainly a sympathetic listener)	330	50	646	50
7.	Non-directive therapy (group)	103	16	145	11
8.	Non-directive therapy (individual)	376	57	680	52
9.	Didactic group therapy (directed group discussion of planned topics)	101	15	197	15
10.	Supportive therapy (encouragement and reassurance; therapist may understand but does not interpret dynamic factors)	333	50	622	48
11.	Interpretive therapy (therapist attempts general dynamic interpretations for attainment of insight and resolution of conflicts)	133	20	210	16
12.	Interpretive group therapy (permissive atmosphere, group and individual feelings discussed and interpreted; may include psychodrama)	408	62	678	52
13.	Psychoanalysis (systematic use of techniques of free association, etc., with interpretations of transference and resistance to achieve goal of fundamental personality reorganization)	82	12	119	9
Therapeutic use of adjuvants:					
14.	Hypnosis	61	9	103	8
15.	Drugs	28	4	39	3
16.	Play therapy	146	22	237	18

Table 19

AVERAGE NUMBER OF HOURS PER WEEK WITH PATIENT

		Total Group N-1302	
		#	%
1.	Average of less than one hour	44	3
2.	1 hour	234	18
3.	2 hours	207	16
4.	3 hours	70	5
5.	4 hours	19	2
6.	5 hours	13	1
7.	6 hours or more	15	1
8.	Omitted	209	16
9.	Reported a range	489	38

Comment on Table 19: There seemed to be a great deal of confusion as to whether the question meant average time spent with one patient or average time spent with all patients in the course of a week. This confusion seemingly is at the root of such figures as 15 of 20 hours which some respondents gave in answer to the question. If the answer to 8e exceeded the answer to 8f, it was assumed that the question was misread and the figures were not coded. There was no general way to eliminate this fault, however, and we simply have to take any results on this item with due skepticism.

Table 20

MINIMUM NUMBER OF HOURS PER WEEK WITH PATIENT

	Total Group N-1302 #
1. Minimum of 15 minutes or less	42
2. 30 minutes	76
3. 1 hour	300
4. 2 hours	42
5. 3 hours	14
6. 4 hours or more	15

Table 21

MAXIMUM NUMBER OF HOURS PER WEEK WITH PATIENT

	Total Group N-1302 #
1. Maximum of 1 hour or less	17
2. 2 hours	36
3. 3 hours	185
4. 4 hours	72
5. 5 hours	82
6. 6 hours or more	96

Table 22

AVERAGE DURATION OF TREATMENT IN HOURS

	Total Group N-1302 #	%
1. Average of 5 hours or less	210	16
2. 6 - 10 hours	191	15
3. 11 - 30 hours	279	21
4. 31 - 50 hours	91	7
5. 51 - 100 hours	54	4
6. 101 - 200 hours	27	2
7. 201 hours and over	20	2
8. Answered by months or years	38	3
9. Omitted	389	30

Table 23

AVERAGE NUMBER OF CASES TREATED PER YEAR

		Total Group N-1302 #	%
1.	5 or fewer cases	81	6
2.	6 - 10 cases	113	9
3.	11 - 20 cases	160	12
4.	21 - 30 cases	108	8
5.	31 - 50 cases	149	11
6.	51 - 75 cases	38	3
7.	76 - 100 cases	69	5
8.	101 - 200 cases	94	7
9.	201 cases and over	89	7
10.	Omitted	399	31

Table 24

REGULAR CONFERENCES WITH REGARD TO CASES

		Total Group N-1302 #	%
1.	No	399	31
2.	Yes, with psychiatrists	109	8
3.	Yes, with psychologists	208	16
4.	Yes, with social worker	19	2
5.	Yes, with psychiatrist and psychologist	99	8
6.	Yes, with psychiatrist and social worker	98	8
7.	Yes, with psychologist and social worker	56	4
8.	Yes, with all three	232	18
9.	Yes, with others specified	13	1
10.	Omitted	72	6
11.	Yes, profession not specified	3	-

Table 25

FORMAL PSYCHIATRIC SUPERVISION WITH IRREGULAR CONFERENCES ON CASES

		Total Group N-1302 #	%
1.	No	855	66
2.	Yes	263	20
3.	Yes, regular conferences	11	1
4.	Yes, other qualifications	25	2
5.	Omitted	144	11

Table 26

HOW ARE YOUR PATIENTS USUALLY REFERRED TO YOU?

		Special Group* N-42		Total Group N-495	
		#	%	#	%
1.	By a general physician	18	43	182	37
2.	By another psychologist	11	26	112	23
3.	By friends	9	24	100	20
4.	Through a phone book	1	2	12	4
5.	By a psychiatrist	15	37	145	29
6.	By a social agency	4	10	64	13
7.	By former patients	19	45	195	40
8.	Other	3	7	83	18
9.	Not specified	1	2	5	1
10.	Four or more items checked	22	52	122	25

*The "Special Group" of 42 respondents reported in the Tables 26 to 31 on private practice was composed in the following way: respondents who (1) checked or double-checked "private practice" in Question 1 on Present Employment, (2) in Question 2 on percentage Distribution of Time indicated they were giving 40 per cent or more of their time to therapy (or counseling), and (3) answered Question 10 on Private Practice. The total group are those stating that they engage in private practice.

Table 27

ACCEPT PATIENTS WITHOUT REFERRAL FOR PHYSICAL EXAMINATION

		Special Group N-42		Total Group N-495	
		#	%	#	%
1.	Always	3	7	25	5
2.	Often	10	24	79	16
3.	Sometimes	15	36	229	46
4.	Never	14	33	143	29
5.	Omitted	-	-	19	4

Table 28

PREFER PRIVATE TO INSTITUTION PRACTICE

		Special Group N-42		Total Group N-495	
		#	%	#	%
1.	Yes	34	81	285	58
2.	No	3	7	142	29
3.	Undecided	4	10	28	3
4.	Prefer combination	-	-	16	5
5.	Omitted	-	-	23	4

Table 29

PLAN TO REMAIN IN PRIVATE PRACTICE

	Special Group N-42		Total Group N-495	
	#	%	#	%
1. Yes	37	88	348	70
2. No	-	-	44	9
3. Undecided	5	12	41	8
4. Omitted	-	-	61	12

Table 30

ACTION TAKEN WHEN PATIENT DEVELOPS SOMATIC DISTRESS DURING COURSE OF TREATMENT

	Special Group N-42		Total Group N-495	
	#	%	#	%
1. Refer patient to a physician or clinic (therapy may or may not be continued)	29	69	260	52
2. Confer with physician	9	21	59	12
3. Refer patient to a psychiatrist	6	14	64	13
4. Confer with a psychiatrist	1	-	33	7
5. If functional, treat it; seek psychological cause, use as an occasion for insight	5	-	37	8
6. Physical steps are patient's responsibility and therapist doesn't assume it	-	-	5	1
7. Action determined by individual case	2	5	20	4
8. Has not occurred as yet	3	7	70	14
9. Other	1	-	28	6
10. Omitted	1	-	30	6

Comment on Table 30: Some respondents misinterpreted the question in the following fashion: they understood it to mean, "What do you do if the patient develops physical distress during the course of a therapeutic session?" This probably accounts for the rather large portion of "Hasn't occurred as yet", or for the people who say, "Well I pass the patient a piece of Kleenex", and so forth. Again another problem was posed by the fact that in some of the replies it was impossible to distinguish whether the respondent meant he referred the patient to a physician for an examination or whether he conferred with a physician to plan a course of action.

Table 31

SPECIAL PROBLEMS OF PSYCHOLOGISTS ENGAGED IN PRIVATE PRACTICE

		Special Group N-42		Total Group N-495	
		#	%	#	%
1.	Public education as to nature and services of clinical psychologists	14	33	82	16
2.	Uncertainty of institutional status; establishment of professional identity and status (different from quacks or psychiatrists)	9	20	75	15
3.	Uncertainty of legal status and responsibility; need for licensure or certification; present need for psychiatrist referral, etc., as legal safeguard.	11	26	108	22
4.	Education of other professions, including physicians and social workers as to role and services of clinical psychologists	7	17	65	13
5.	Difficulty in securing medical diagnoses, reports and/or simultaneous treatment	-	-	15	3
6.	Elimination of hostile attitude of psychiatrists toward psychologists doing therapy	3	7	13	3
7.	Elimination of hostile attitude of M.D.'s (other than psychiatrists) to psychologists in field of psychotherapy	1	-	11	2
8.	Better cooperation with psychiatrists	2	5	30	6
9.	Better cooperation with M.D.'s (other than psychiatrists)	5	12	65	13
10.	Inadequate opportunity for discussion of cases	3	7	24	5
11.	Proper selection of cases, confined to scope of therapist's own training	3	7	42	8
12.	Maintaining professional ethics and standards	6	14	38	8
13.	The problem of setting and collecting fees	1	-	19	4
14.	Social work with or treatment of other members of patient's family	-	-	11	3
15.	Other	16	38	191	38
16.	Omitted	16	38	77	16

Discussion of Table 18 - Therapeutic Approaches Employed

In working with the data from this question, it soon became obvious that we faced a problem of gross multiple checking which might well invalidate any conclusions drawn from the responses to this question. In order to investigate the seriousness of this factor, the various items in this question, insofar as the total percentages indicated that they were important, were run against one another. When this was done the following results were obtained:

1. More than one-half of the respondents who checked Vocational Guidance also checked Release Therapy, Non-Directive Individual Therapy, Supportive Therapy, and Interpretive Group Therapy.

2. More than one-half of the respondents who checked Marital Counseling also checked Sex Education, Vocational Guidance, Release Therapy, Non-Directive Individual Therapy, Supportive Therapy and Interpretive Group Therapy.

3. More than one-half of the respondents who checked Release Therapy also checked Vocational Guidance, Non-Directive Individual Therapy, Supportive Therapy and Interpretive Group Therapy.

4. More than one-half of the respondents who checked Non-Directive Group Therapy also checked Release Therapy, Non-Directive Individual Therapy, Interpretive Individual Therapy and Interpretive Group Therapy.

5. More than one-half of the respondents who checked Non-Directive Individual Therapy also checked Vocational Guidance, Release Therapy, Supportive Therapy and Interpretive Group Therapy.

6. More than one-half of the respondents who checked Supportive Therapy also checked Vocational Guidance, Release Therapy, Non-Directive Individual Therapy, and Interpretive Group Therapy.

7. More than one-half of the respondents who checked Interpretive Group Therapy also checked Vocational Guidance, Release Therapy, Non-Directive Individual Therapy, and Supportive Therapy.

8. More than one-half of the respondents who checked Psychoanalysis also checked Interpretive Group Therapy.

Thus, (with the exception of those checking Psychoanalysis) Release Therapy, Non-Directive Individual Therapy and Interpretive Group Therapy were checked by more than one-half of each group; Vocational Guidance and Supportive Therapy were checked by more than one-half of each group, except for those checking Non-Directive Group Therapy.

It would seem, then, that Release Therapy, Non-Directive Individual Therapy, Interpretive Group Therapy, Vocational Guidance and Supportive Therapy form a cluster of approaches that are either used by the same individuals en masse, or were, for some reason, indiscriminately checked by a large percentage of the respondents. Sex Education, Speech Correction, Tutorial Therapy, Didactic Group Therapy, Interpretive Individual Therapy, Psychoanalysis, and Hypnosis, tend to be checked more independently.

One cause of this multiplicity of checking lies probably in the fact that of the titles given, some seemingly refer to the end or purpose of the therapy, (e.g., Sex Education, Tutorial Therapy) while others refer to the methods employed (e.g., Supportive Therapy, Non-Directive Therapy). Thus, a certain amount of multiple checking might well have been expected. It is interesting to note that those approaches which were most independently checked seem to be those that are most circumscribed either as to purpose or technique; those which were most "dependently" checked are more diffuse in these aspects. Here we have further evidence of the general confusion about the referents of terms designating methods, approaches, and goals which we referred to in Part II on the Evaluation of the Data.

Breakdowns of "approaches used" by place of employment, degree held, per cent of time given to therapy, and combinations of these did not significantly differentiate such subgroups from the total group of respondents.

IV. Private Practice

Psychologists as well as members of allied professions have been concerned to know how many psychologists are engaging in private practice. We bring together here the answers to this question supplied by the analysis of the returns from the second inquiry. In answering Question 1 on Present Employment, 27% (346) of all respondents single-checked "Private Practice". About a fourth of the respondents, then, engage in some private practice. 5% (60) by double-checking "Private Practice" in Question 1 indicate that they regard it as one of their primary activities. (But 49% of the respondents made no double-checks on Question 1.) To Question 5, "Present Position", 1.7% (22) answered, "Therapist in private practice", and 2.4% (31) answered, "Consultant". The latter term, of course, may not in all cases refer to the practice of therapy. If we were to assume that our respondents were an unbiased sample of the 5754 members of the Association in 1948 and were to limit ourselves to Question 1 and 5, we would answer the question, "How many psychologists are engaged in the practice of psychotherapy (or counseling)?" by saying, "About one-fourth of the membership (1400) engage in some of this activity, and about one-twentieth (285) are principally so engaged".

When, however, we seek the answer to the same question from the replies to Question 10 on "Private Practice", we get a different answer. Here 38% (500) state that they engage in private practice. This figure is larger by 6% (94) than the double and single checks combined in Question 1. We are uncertain of the truth of our answer not only on the grounds of the representativeness of the sample, but also on the grounds of the accuracy of the respondents.

The question of greatest concern for many purposes is, "How many psychologists are chiefly engaged in private practice?" To get as accurate an answer as possible, we composed the Special Group reported in Tables 26-33. The criteria for the selection of this group were three: (1) In Question 1, the respondent either single-checked only private practice or he double-checked it, (2) he indicated in Question 6 that he is giving 40% or more of his time to psychotherapy (or counseling), and (3) he answers, "Yes", in Question 10 to the question, "Do you engage in private practice?" This group is composed of 42 respondents. If we assume an unbiased sample and accurate answers, the answer to the question, "How many psychologists are chiefly engaged in private practice?" is about 3.2% (185) of the total APA membership.

The age distribution of the group is given in Table 32.

Table 32

Age Distribution of Those
Chiefly Engaged in Private Practice

N-42

Age	N
25-34	3
35-44	21
45-54	13
55-64	3
omitted	2

Table 33

Special Group in Private Practice
Distribution by States

N-42

States	Practitioners	
N	N	
8	1	Connecticut, Florida, Idaho, Maryland, Michigan, Minnesota, Ohio
4	2	Illinois, Kentucky, New Jersey, Washington
1	3	Massachusetts
1	6	New York
1	11	California
	3	in foreign countries
	3	unidentified

The following data throw light on the training of the Special Group. 29 have Ph.D.'s, 11 M.A.'s, one an M.Ed., one no degree. But note that the respondent with no degree and three of the M.A.'s report that they are diplomates in professional psychology. 29 have had personal therapy; and 22 of the 29 have been psychoanalyzed.

The issue psychotherapy versus counseling crops up again here. Five respondents indicate explicitly that they do not regard their private practice as therapeutic, but rather as educational and vocational counseling. It appears that their work is largely with problems of adjustment of their clients to new or changing life situations rather than with problems involving the modification of symptoms or of personality structure.

It will be observed (Table 26) that a large proportion of the cases seen in private practice are referred by members of the medical profession. And from the Table 27, it appears that, regardless of whether the respondents are chiefly engaged in private practice or devote only a small amount of time to it, about a third never accept a case without referral to a physician for a physical examination. Among the respondents chiefly engaged in private practice, none report difficulties in securing medical diagnoses, reports, and/or simultaneous treatment.

Four-fifths of those chiefly engaged in private practice prefer it to institutional; and almost nine-tenths plan to remain in private practice.

The special problems reported by these 42 respondents are in kind as well as in frequency substantially what we would have surmised. A third find it a handicap that there has not been public education as to the nature and services of clinical psychologists. (The Committee believes that public education through mass media now would be premature and would not serve the interest of the profession. We need first to define the role or roles of psychologists in private practice in terms of kinds and levels of competence and to be able to validate such roles in considerable numbers through graduate and post graduate training and supervised practice. In the interim the individual practitioner must create and justify his role with some local sub-public. For the present, we believe that the Division, indeed the Association, should view each private practitioner as a pilot study for a potential profession.) A fifth can only report as a problem establishing in their own community their professional identity and status. A fourth indicate the uncertainty of their legal status and responsibility as a problem. A sixth feel that other professions, including physicians and

social workers, need education concerning the role and services of the practicing psychologist.

V. Data from Open-Ended Question

For a consideration of the last item of the questionnaire, soliciting comments on or suggestions concerning the questionnaire or the field it attempted to cover, the quantitative approach seemed inadequate. The comments were so varied in relevance and thoughtfulness, and their content so diverse that no schematic treatment of the data they presented could have been satisfactory. Some 240 individuals included comments that were of general interest. Among these comments were 137 that related to training, including the selection of candidates; 32 that related to community needs for psychological service; 18 that concerned public relations; 62 that concerned relations with other professions, especially the medical profession; 22 that touched upon the relations of research and therapy; 13 involving ethical matters; and 58 that were of a miscellaneous character.

In this preliminary statement, we shall report on certain of the issues that emerged. The data are included with confidence in spite of their small numbers, because the comments were spontaneous and evidently the issues which were uppermost in the minds of the respondents. We feel that the measure of their importance lies in their location at the heart of the present status of our field.

A. Research versus service role of psychologists in therapy

The first issue is an intensely provocative and wholly unsettled one. It might be phrased in the question, "Why should clinical psychologists do therapy anyway?" We find in our data answers that line themselves up on opposite sides of the question. There are those who, with thought and with the patent desire to be of the greatest ultimate service to mankind, state unequivocally that in their belief, the function of the clinical psychologist in his therapeutic role is that of the scientist who brings his questioning orientation and research skills to a field that has for so long been the sole province of the artist and the technician. His duty is, in the first place, to subject the tools of the therapist, which have become his tools, to his dispassionate scrutiny, to lay bare their flaws and to point the way to their further improvement. This cannot be the province of the medically trained therapist, whose interest lies in curing and whose training has not included the rigorous exercise of critical thought and the learning of research skills, it must fall to the psychologist, whose training has.

Furthermore, the psychologist in the practice of therapy should never overlook his position as the student of behavior and its generalities. It is because the therapeutic situation provides the opportunity to arrive at the most basic data out of which he can formulate laws and principles that he should interest himself in this field. These principles may themselves be of value in the prevention or more efficient treatment of human ills--this is the hope--but the curing of the individual patient is of secondary importance. Quotations, representing this point of view, follow:

> To me, the great danger of the psychological therapist is to become submerged in his service demands, and lose research orientation and skills. Our unique contribution to humanity lies not in our service to individual patients but in our research contributions concerning that patient. To me, this is the only justification for our encompassing the practice of therapy in our professional interests.
>
> It is my opinion that psychologists should remain research oriented in their clinical practice. If we don't make systematic contributions to knowledge,

> our progress in understanding, therapy is likely to be very slow, and dependent on the emergence of people with great insight who are all too rare.
>
> I am much concerned that psychologists, or some research-minded and gifted ones, shall have a chance to sit at the window of the psychotherapist and see higher mental processes among humans in action. Despite the gains, the incredible gains, of Freud, we are still in a backwoods stage if the venture is viewed as science. It seems to me that it is not so much the aim of the psychologist to acquire and apply the half-portions of knowledge we now have, as to acquire and improve the whole process. The psychiatrists have stumbled into a field of data--behavior data--with which they have no primary competence to deal from a research standpoint. We do have the research skills to systematize this field and I feel we should get at it.

But there are other psychologists whose beliefs differ sharply from those quoted above. With deepest sincerity and humility, they feel that their purpose in therapy is to serve the patient. As long as the therapist feels his primary concern to be anything other than the welfare and well-being of his patient, he cannot function effectively. This should be his main goal; if it isn't, he has no right to commit himself to the patient, nor to ask the patient to commit himself to him, as the therapist always must.

> An effective, self-confident group is needed who practice therapy and can meet the psychiatric profession...A "service" approach and recognition of its significance needs implementation by us.
>
> I am strongly against the training which teaches the counsellor to look upon his client as a statistic or datum for a paper or research project. We must find people who are interested in the client and his problem rather than in the area of determining general laws, proving theories, or experimenting with therapeutic devices.

B. Type of training for therapy

As might be inferred from the differing opinions expressed by the respondents with regard to the major function of the psychologist in therapy, there is a paralled divergence of opinion regarding the training that should be offered to qualify a psychologist for the practice of therapy. Some deplore the specialization of subject matter that concentrates on dynamics and technique at the expense of broader background; others complain that the four years of graduate study are hardly enough to learn all the specialized knowledge that must be known before the psychologist is even minimally equipped to practice his profession. Thus, on the one hand, we have such statements as the following:

> Let's not become 'lay' 'technicians' or 'aides' to the medical profession. They need the stimulus of 'professional equals' to challenge, stimulate and supplement them. As social 'scientists' we must not become too clinically oriented.
>
> I believe all the people who are being trained in clinical psychology today should be given a thorough grounding in the basic aspects of psychology--experimental, theoretical, historical, etc.; I believe this training would prevent some of the shoddy work which is being done today.
>
> From contact with clinical psychology internes I have developed concern regarding the inadequacies of their training in (a) scientific methodology,

(b) general psychology, i.e., perceptual theory, social, physiological, and learning theory. Most seem to have gone overboard for 'dynamic' formulations and are concerned with little else. I wonder whether these individuals will be equipped to make the research contributions which I believe to be a major function. Too many 'new' clinicians are clinging to the coattails of psychiatrists. They seem to be in the process of converting clinical psychology into junior grade psychiatry.

Yet I believe it is very important that students (counseling and clinical) become exposed to training under such persons who are not fully occupied in counseling and psychotherapy but who are doing work frequently closely related thereto and who may be engaged in some of the basic research that underlies the practice of clinicians and may stimulate these would-be clinicians to be more research minded and teach them techniques so that they may recognize research problems more readily and be more capable of doing sound research on these problems.

Parenthetically, one might insert the comment of another respondent who has also pondered this question, applied his clinical insight, and offers a different answer.

The general lack of professional security shown by clinical psychologists in their reluctence to do pioneering work in therapeutic situations, and the related desire to be orthodox and conservative, has, I strongly believe, prevented or delayed the development of distinctly psychological contributions to counseling and therapy at a rate proportional to the quality and number of workers in the field...A clarification of the function and status of the clinical psychologist for acceptance by both the general public and physicians and psychiatrists would liberate an enormous amount of energy for research.

But the statements are equally strong from the members of the opposite camp, who feel that training for therapy should be that and only that.

I feel a great deal of attention should be paid to divorcing psychotherapy and other aspects of clinical psychology from the traditional academic atmosphere. Clinical psychology is constructed by the 'laboratory' atmosphere and emphasis of the university. A non-Ph.D. degree at the doctoral level should be considered for clinical psychologists...Training should attempt to inculcate an attitude of responsibility to the patient similar to that of the medical schools.

My training (graduate) was academic, theoretically sterile and narrow, in the sense of reflecting physiological bias of men who were ill-informed except in experimental, psychometric and statistical. I see that so-called academic and experimentally oriented professors sit on the committee for training in clinical psychology--we will grow as a profession when those who are clinicians from the firing line outline training plans on the basis of real experience.

Would like to have the research aspect of the Ph.D. degree minimized, and therapy maximized.

Suggestion: Improve university training facilities and have them put more emphasis on realistic clinical training by competent clinicians who are active in the field and currently engaged in the use of modern techniques.

> It has been my experience, and apparently the experience of clinical psychologists with whom I have had professional associations, that whatever skill we have achieved in dealing with personalities under stress has been achieved without significant guidance from academic contacts. Psychology courses emphasizing repetition of past scientific experiments do not necessarily teach the scientific methodology and attitude necessary for scientifically valid research and therapy.
>
> The outstanding flaw as I see it is forcing clinical psychologists to go back and get their doctor's degrees and making them pass the terrific comprehensives in the experimental field. What does that mean? It means that we must forget clinical psychology for a year and a half minimum and study Watson, Hull and Kellog. In two years one can forget a lot of psychology. Mainly the universities require so many requirements such as theories and experiments in rat learning, super-dooper advanced statistics, that we cannot hope to pass them and still take the one or two courses in clinical that may be of some value...If you are going through with the Ph.D. requirement—why can't it be in clinical psychology, and not rat or research?

An additional issue with respect to the training of the clinical psychologist for therapy that is relevant at this point is the consideration of who it is that can best train him for this function. Once again, opinions vary. Some stress the value of medical background and instruction by medically trained practitioners, especially, while at the same time deploring the academic taint that has characterized university training programs in the past.

> I think we have the paradoxical situation today where many psychiatrists are not schooled in psychology and many clinical psychologists are not trained in the medical sciences. If we are to consider and treat men as an integrated whole then we must study man as a system of structures that functions differently when the internal and external environment is changed. We must study not only psychosomatics but somatopsychics as well. I advocate an intensive background of psychology and medical sciences for any prospective therapist.
>
> It would be extremely helpful if psychiatry and psychology would get together...A clear recognition that each can learn from the other...is necessary. Well planned university work toward psychological background for psychiatrists and medical background for psychologists would help.
>
> Neither the present medical nor psychological training...are adequate. It will need to be inter-disciplinary training, in the biological, psychological and social (sciences).
>
> My request of you is that you study and pass on to clinical psychologists in universities all the ways and means of securing the cooperation of psychiatrists and social workers, where available, to work part time for the university clinic. The clinics in a number of universities I know are not doing the best job by their own case load or as a training center because of the lack of these services. Students need association with psychiatry early in their graduate work, especially if they are to become useful as therapists.

Others envisage the training programs as mainly in the hands of psychologists, either by choice, or by necessity, in view of the hostile attitude of medical training centers

or their prior obligations to train their own candidates. They deplore the lack of competent and willing teachers of psychotherapy among clinical psychologists, or the fact that such as there are have not been exploited in the present training programs.

> I believe that institutes for training psychologists in psychotherapy might be set up in various parts of the country...The teachers and staff at first would have to be psychoanalysts and psychiatrists. But as we got our own people trained some of these would in turn become teachers and ultimately the faculties of these institutes would be made up mostly of clinical psychologists.
>
> The demands for psychoanalytic training among psychiatrists is so heavy that there is little possibility of psychologists being accepted on a training basis by institutes for psychoanalysis for quite a few years. Psychology will have to pull itself up by its own bootstraps if we are to get analytic training. Some effort should be made to organize institutes of psychoanalysis for psychologists drawing from the limited teaching resources that we have, utilizing therapists like Reik, for example, and other lay analysts.
>
> Especially I would like to see the inauguration of an analytic training school for psychologists. After all, some of the best in this field are Ph.D.'s. Why not try to enlist their aid in such a project?
>
> I am of the opinion that in the training of clinical psychologists and/or psychotherapists there should be much more stress placed upon supervision by experienced clinical psychologists and/or psychotherapists. While an orientation to psychology certainly is indicated for anyone entering these fields, I think it is ridiculous for so much psychiatric supervision to be demanded without a similar demand that the clinician and/or therapist (psychologist) receive instruction from someone in the very field he is entering. One might as well insist that all nurses receive the entire body of the practical instruction from physicians and ignore the contribution that can be made by experienced nurses themselves.
>
> I feel that those members of the profession who have received competent and thorough training in therapeutic techniques should undertake the prime responsibility for the training of other psychologists. Groups of such therapists in each section might organize therapy seminars on specific cases for those actively engaged in therapeutic work. It might be possible also for such groups to arrange discussion periods by leading therapists for the particular area.
>
> But I do not believe that this control work necessarily has to be (under) a psychiatrist. It would be better if we don't create the impression as if psychologists can only work under the supervision of a psychiatrist.

c. The selection of candidates for training in therapy

Whatever else may be the subject of disagreement among the respondents who offered their comments and suggestions at the end of the questionnaire, there was one topic upon which there was a unanimity of opinion. All agree that the present methods of selection of candidates for training in psychotherapy, methods which lay such great stress on academic successes, are inadequate. Intelligence as measured by the ability to get A's in college courses is seen as the minimum requirement for a good therapist, the necessary but not alone sufficient quality. Other qualities--stability, maturity, insight, sym-

pathy--must also be present. These do not seem to be receiving their due weighting in the evaluation of potential therapists in the selection or training stages of their professional education.

> Not all psychologists suited by temperament to be therapists, and not all want to be.
>
> The crucial significance of the personality make-up of the therapist not brought into foreground in most present training programs--I would put it this way: therapy cannot be learned unless it has been experienced.
>
> Far more attention must be paid to the personality structure of the graduate student planning to do therapy--there has been much too much emphasis on academic and intellectual prowess, and too little on the maturity and stability of the personality of the potential therapist.
>
> There should be very definite requirements set up for entrance to courses in psychotherapy in colleges and institutions. Students are presumably served by various methods for these courses but in the final analysis it is usually dependent upon their matriculation for the doctorate degree. This, of course, in no way certifies that the individual is qualified to prepare himself for therapy. I should like to see a much more careful screening of individuals for therapy courses...Serious damage can be done by so-called 'therapists' who have never freed themselves from their own conflicts before working with others.
>
> I feel that the move of the VA in the direction of evaluation of clinical psychology students was excellent and that not only intelligent but emotionally stable, mature individuals must be found for clinical psych work. There is entirely too much 'casework' being done by students whose psychological information, let alone their personal maturity, is totally inadequate.
>
> Too many screwballs who are misfits in college and elsewhere, somehow wind up as students of 'clinical psychology'. They get a masters or doctorate and then proceed to 'give treatment' with little or no real insight into (a) their own immaturity and conflicts, (b) those of the unwary patient. Consequently as a first step, suggest that would-be psychologists be screened pretty carefully before being allowed to enroll in clinical psych program.
>
> An important factor is the manner and personality of therapist. This is not revealed in formal training or in any other stereotyped formula. There are those who have the correct training and the correct theories and methods who are still inadequate. How this is to be measured for certification purposes I do not know, but that it is more urgent in clinical than in somatic therapy should be recognized.

Most of us would agree with the last-quoted respondent; we do not know "how this is to be measured"; many of us would even venture to say that we don't even know what it is that should be measured. That there can be difference of opinion on the method of assaying these intangible qualities, however, even while there is none on their importance, can be seen from the following:

> I think people to be trained for therapy should be highly selected by

objective clinical methods.

as contrasted with:

One of the most important angles for doing psychotherapy, talent and natural gift, which cannot be substituted for by any amount of training does not seem to be covered. This can only be evaluated through adequate supervision.

D. Community need for service

Still another focus of agreement among those who chose to express themselves on the point is on the question of the great and as yet unmet need for therapeutic services on the part of large segments of the population. Such comments came from psychologists working in vocational guidance bureaus, in mental hospitals, in VA installations; from clergymen; from private practitioners; but most of all, they came from psychologists whose primary positions were academic, but who were forced into an active counseling or therapeutic role by the demands of the student population.

I suspect that there are many men who like myself have full-time responsibilities along other lines who are nevertheless drawn into the field of counseling because of the great need. We are doing the best we can, and certainly I think we do more good than harm. Still, we need help, and if you can supply it, please, please do.

As an instructor in psychology, students have gravitated toward me in their need for assistance. Other facilities not being available for the less severe distress, I feel obligated to do what may be possible with what little we have to do it with.

Those of us who are psychologists and are interested in personal and social adjustments have to take responsibility of a very diverse nature when we are in small colleges. The most serious cases we refer because we do not have the time or the facilities to handle them.

My report may not be within the proper range of your inquiry. But it would be absurd to suppose that psychologists in teaching positions do no clinical or therapeutic work: it is in greater or lesser degree forced upon some of us... So far as possible, I function as a preliminary diagnostician. If the case seems to warrant or require psychiatric help, I try to arrange for this; if the problem appears to be situational, or a problem of adjustment, I am virtually compelled to give such help as I can, since psychiatric services are not usually available, even if advisable.

It seems to me that there are rather special problems of the psychologist in small colleges which should have and do not have psychiatric service or regular clinics. These departments inevitably get many problems referred to them unofficially and often they are in a better position to handle these cases than anyone else available even though they aren't as well trained as they should be. Often they prefer not to do counseling for lack of time, training, etc., but become involved because there is no alternative. This group needs some attention. Some training opportunities might greatly increase the effectiveness of such people or perhaps convince them of what they don't know.

There are too few qualified psychotherapists and counselors...As the area of most immediate concern to me, the academic field strikes me as a place where continued and readily available services are essential. The psychologist on the campus is thus in a position of unusual social responsibility and often

this is not clearly defined; yet he cannot, as things stand now, very easily avoid fulfilling some, at least, of this responsibility.

There are times when I feel that speaking of my activities as "therapy" is akin to the Howard Johnson practice of terming hamburger "Salisbury steak". Actually, I handle a highly variable number of students with a wide range of personal and scholastic problems, who come to me voluntarily because they "want someone to talk to", "have something on their minds", or are vaguely perplexed or puzzled. They sort of fall between the chairs in this impersonal situation. Their troubles are not administrative and hence they are not seen by any dean; often they are not sufficiently scholastic to justify seeing an academic "adviser", who is represented as a figure who knows all about course requirements, program needs, etc., but little about people; and usually the counselee's situation is not such as to have delivered him into the hands of the university psychiatrist because he is getting into trouble with his roomates or the police...I imagine there are a fair number of people like myself who have read some of the articles and books the Rogers school puts out and have a generalized smattering of psychological therapeutic methods, but who don't perform regularly enough to make them feel uncomfortable about not being formally trained, and a little sheepish at the title "therapist". I need a little reassurance myself, sometimes, and the only reason I keep on is that there is no other convenient source of help for these students.

The need for psychotherapy in VA installations is acute, and I believe patients can be helped by devoting a large proportion of time to therapy and somewhat less time to diagnostic testing. If we spend most of our time testing and diagnosing patients we then have no time left to treat them. Consequently, many patients do not improve because nothing is done for them. At this hospital, psychologists are the only people doing psychotherapy and we can take care of only a small fraction of those patients requesting it.

I found in _____ that there was enormous demand from pediatricians for people to work with their "behavior problems" or neurotic patients, and the private practice I did there was confined to that level. In general I have little desire or time for private practice, but have found that great pressure is put on me to take cases (the same is beginning to be true here)--and in self-defense usually end with a couple of paying cases running along all the time.

Most serious vocational guidance problems present problems in personality adjustment. Some of these basic difficulties involve serious complications and should be referred. However, it has been impossible to continue to say, "there are more basic problems here--a vocational counselor cannot at this point help." It became necessary to consult individuals with adequate background and experience--and try to work out some of the simpler cases under their direction.

Originally hired chiefly for tests, I have become Jack of all trades for the simple reason that I couldn't ignore opportunities and needs, and other trained services have not been available. Patients often ask for talks. I try to find ways of helping the difficult...I do much which would not get done otherwise, though it cannot be put in statistics.

Such are the needs and opinions of our respondents, and the pressures put upon them. There could hardly be a better way to end this report than to echo one of our colleagues:

> There are thousands of people in emotional distress in this country who cannot get the proper help because there are not enough psychiatrists 'to go around'. We, as psychologists, could help alleviate this need, if we had adequate training for therapy. I find myself, time and again, shying away from taking on many a therapy case who comes begging to me for help, because I feel I have not enough training and therapeutic experience to handle it properly. It becomes a question of our social conscience: Should we give therapeutic help knowing that our training has been inefficient and that we risk making mistakes which may be harmful to the patient—or should we refuse help altogether and advise the patient to get on a psychiatrist's three-year waiting list? Neither alternative can satisfy my social conscience. The only right answer can be to train more psychologists adequately for therapy.

VI. Recommendations

(Action taken regarding these recommendations by the outgoing Executive Committee of the Division at its meeting on September 3, 1950, is indicated in parentheses.)

1. That a condensed version of this report be published as a supplement to the Newsletter of the Division. (Approved)

2. That in view of the expressed need of a large number of respondents for postdoctoral training of various sorts:
   (a) These needs be reported to the several state psychological associations with the recommendations that they institute local training courses. (Approved)
   (b) The Committee on Postdoctoral Training consider offering its services to the state associations, e.g., advice on teaching personnel and admissions policies. (Approved)
   (c) That the Committee on Postdoctoral Training consider the feasibility of extending its training institutes in number and length, possibly by arranging regional institutes to be held in university buildings and to run concurrently with summer sessions. (Approved)
   (d) The Committee on Postdoctoral Training consider the practicality of having one or more "roaming supervisors of practice" who would operate in a circumscribed area where there are a number of psychologists engaging in psychotherapy-counseling who have expressed a need for consultations or supervision with an experienced psychotherapist or counselor. (No action taken)

3. (a) That the Executive Committee request the Program Committee to consider the feasibility of organizing seminars to work on the problem of improving the articulation of the phenomena, terminology and conceptual schemas of clinical and experimental psychology. This is regarded as an important if indirect means of improving the training of clinical graduate students in psychology. (Referred to the Program Committee)
   (b) That the Executive Committee recommend to the state and regional associations favorable action of the same kind. (Approved)

4. That in view of frequently expressed need among the respondents for more and better facilities for self-exploration:
   (a) The new Psychotherapy Committee be appointed to prepare a detailed report on policies, practices and methods currently in use which are designed to meet this training need. (Referred to Postdoctoral Training Committee)

(b) The Division take the iniative in having a symposium prepared and published in one of the Association journals dealing with (1) the nature and range of self-knowledge necessary in psychological counselors and (2) effective and economical ways of securing it. (Referred to Postdoctoral Training Committee)

5. That the Executive Committee consider taking the iniative in securing funds and facilities for exploratory research on more adequate and economical means of giving training in self-knowledge. (Deferred until 4a and b are carried out)

6. That the Division and Association keep an open mind on the issue of independent practice; and that the representatives of the Association who confer with representatives of psychiatry and medicine delay concluding agreements which might freeze in a disadvantageous way the status of psychologists in independent practice until the opportunity is had for appropriate committees of the Division and Association to examine the merits and implications of the views here set forth concerning independent practice. (Approved without specific suggestions from the Executive Committee)

7. That copies of the above recommendations be sent to the (1) Council of Representatives and (2) Committee on Relations between Psychology and Psychiatry. (Approved with the suggestion that the Committee on Relations between Psychology and Psychiatry be sent a copy of the complete report)

8. That contrary to the suggestions of some respondents, no effort be made now through mass media to acquaint the general public with the nature of the services of clinical psychologists in independent practice. "The Committee believes that public education through mass media now would be premature and would not serve the interest of the profession. We need first to define the role or roles of psychologists in private practice in terms of kinds and levels of competence and to be able to validate such roles in considerable numbers through graduate and postgraduate training and supervised practice. In the interim the individual practitioner must create and justify his role with some local sub-public. For the present, we believe that the Division, indeed the Association, should view each private practitioner as a pilot study for a potential profession." (It was felt that the question of private practice is not sufficiently clearly defined at this point to take a stand on the problem of public education. It was moved and carried that this recommendation be accepted as representing the attitude of the Executive Committee and that this should be called to the attention of the Public Relations Officer of the APA.)

9. That the Secretary of the Division be instructed to express to Prof. Samuel Stouffer, Director of the Laboratory of Social Relations, Harvard University, the appreciation of the Division for his helpful advice on processing the questionnaire and for the use of the Laboratory sorting machines. (Approved)

(The incoming Executive Committee at its meeting on September 7, 1950, acted as follows regarding the above:)

Recommendation 5 is to be referred to the new Psychotherapy Committee for their suggestions for implementation. The discussion of this recommendation brought out the general feeling that the recommendation is somewhat unrealistic and that there is no evidence that those who have had personal therapy are better therapists than those who have not. Recommendation 6 was approved and a memorandum is to be sent to the APA Board and committees.